Improving the Public's Health in New Hampshire

Public Health Improvement
Action Plan Advisory Committee Meeting

June 15, 2006
Local Government Center

In Attendance:

Voting Members: James Squires, Thomas Clairmont, Mary Ann Cooney, Margaret Franckhauser, Kevin Flanagan, Judith Fillion, Jonathan Stewart, Yvonne Goldsberry, Marylee Greaves, Russell Jones, Ann LaFlamme, Shawn LaFrance, John Seavey, Mary Vaillier-Kaplan, Norrine Williams, Marilyn Duffy,

Non-voting Members: Joan Ascheim, Alice Ely, Maureen Farley, Kate Frey, Jose Montero, Jennifer Ritchings, Cheryl Storey, Lisa Bujno, Emmanuel Mdurvwa, Corrine McCandless

Not Attending: Peter Batula, Greg Moore, Mary Nelson, Cindy Rosenwald, John Martin, Christine Bean, Richard Rumba, Neil Twitchell, Kate Kokko, Kathy Bizarro, Christine Adamski, Fred Rusczek, Margaret Murphy, Jeanie Holt, Deborah Hogancamp, Brian Lockhard (resigned membership)

Welcome and Introductions:

Mary Ann Cooney and Dr. Squires welcomed group members and spoke to the importance of the task of the day; to set strategic priorities for the public health improvement process.

Forces of Change Assessment

Joan led the group through a forces of change analysis, one of the assessment tools of the Mobilizing Action through Planning and Partnerships model. PHIAP members were asked to answer the question, *"What is occurring or might occur in New Hampshire that affects the state public health system and our goal to undertake a public health improvement process?"* For each external trend or force, members were asked to identify accompanying challenges and opportunities. These were recorded, printed and distributed to members at the meeting. (Attached at the end of the minutes).

State Assets

Joan reviewed state assets that were identified by public health stakeholders at the October meeting at which NH conducted the National Public Health Performance Standards. Those assets were:

•Many committed individuals working to improve public health.

•Many valuable technical assistance resources at the state, academic centers, and in not for profit foundations and institutes.
•A broad array of public health activities exist for many essential services-data reports, surveillance, training, health education, coalitions, planning, policies, monitoring, health services, performance improvement, research (pages 45-56 of report).
•We have professionals skilled in data collection and surveillance.
•Increased epi capacity in the state and partnerships between academia and practice.
•Small state and limited resources encourages collaboration.
•Strong enforcement structure
•Healthy state with high insurance coverage.
•Nurse practitioners able to serve as primary care providers.

PHIAP members identified additional assets:

- Proactive public health association that advocates for public health.
- Support for public health from insurance companies, such as in their payment for immunizations.
- Collaboration among medical directors of health plans.
- High level of internet access.
- Two strong local health departments.
- Small state can be a laboratory to test out models and be a prototype for other states.

State Strengths and Themes

PHIAP members broke into three groups to answer questions adapted from the Mobilizing Action through Planning and Partnerships model. The questions and responses are below.

1. **What are some issues or events that have brought communities together successfully to improve the health and quality of life in our state and that we can learn from?**

- Environment – debate and action
  Understanding of what it means to us
- Avian Flu – regional planning, players at the table (fire, rescue, police), learning lab for public health
- Flooding – brought together unusual players, FEMA, local
- Mill closures in North Country – health insurance access
- Child health – debate, New Futures
- Smoking – a lot of progress
  Restaurants – reframed debate from personal choice to business to workplace safety
- NH Healthy kids – health insurance for children
- Refugee health – a beginning debate
  Lead issues
  More awareness
- Newborn screening – public at the table – weighed in on what we test for
- Education funding – raise issue to level
- Contraception – over the counter accessibility
- Flu vaccine shortages – focus on necessity of vaccine
  Raises awareness of vaccination
- Turning Point

- When we have a crisis – we pull together and form partnerships

2. **What are the 2-3 most important characteristics of a healthy state public health system?**

- Sustainable funding
- Strong, sustained leadership
  - Vision
  - Articulate – public, legislature
  - Flexible and responsive
- Availability of timely, effective collection and dissemination of data
- Legal authority at multiple levels – state, regional, local
  - Decision making
  - Buy in

3. **What are the 2-3 most important issues that must be addressed by the state public health system to improve the health and quality of life in our state?**

- Leadership and advocacy
- Preservation of funding
- Strong communication plan
  - State lead w/ focus on stakeholders
- State should guide and set goals
  - Strategic
  - Specific to populations and locations
- Epidemiology
- Formalized leadership body

Common Themes

Several common themes emerged as a result of these assessments. They were:

- The need for strong leadership.
- Crisis provides an opportunity for partnerships and working together.
- Epidemiology capacity is important
- The need for a strong communications plan
- The need for good data
- Funding – Public health funding crisis

Review of Essential Services

A PHIAP member presented each of the ten essential services to the group. The presenter summarized the essence of the essential service and the score and ranking it received in October. They reviewed the priority activity recommendations for the service made at the October meeting. PHIAP members then added priority activities to each essential service.

Voting and Selection of Strategic Priorities

Considering all the above, PHIAP used a two-tiered voting process to determine strategic public health priorities.

Each PHIAP member was given four dots and asked to vote on the top four most important essential services using the criteria of importance previously determined.

Those four essential services were:

1) Inform, educate and empower people about health issues - 11 votes
2) Monitor health status to identify and solve community health problems- 10 votes
3) Mobilize community partnerships and actions to identify and solve health problems –8 votes
4) Develop policies and plans that support individual and community health efforts – 8 votes

For the second tier of voting, PHIAP members were asked to look at the priorities identified under each essential service and consider if there were any priorities or common themes among them that were so important that they warranted attention separate from the essential services.

The following priorities emerged from this voting:

State level leadership – 10 votes
Communication plan- 10 votes
Technology – 8 votes
Workforce development plan- 8 votes

The group discussed whether or not these priorities should stand-alone and required a separate work group to develop an action plan around them, or if they fit with any of the other identified priorities.

The final strategic priorities endorsed by PHIAP were the following:

1) Inform, educate and empower people about health issues
2) Monitor health status to identify and solve community health problems
- These two groups will be asked to integrate improved use of technology into their strategic action plans.

3) Mobilize community partnerships and actions to identify and solve health problems
4) Develop policies and plans that support individual and community health efforts
- This group will address the need for a state leadership focus such as the advisory committee and an ongoing state health improvement planning process.

5) Communication plan
- This group will have representation of all other groups on it.

6) Workforce development
- This group will be charged with developing a workforce development plan

Next Steps

Vision Development

During the summer a group of DPHS staff and PHIAP members will work with consultants to develop a vision for DPHS. Articulating a clear vision for the future will be an integral part of the public health performance improvement plan.

September Summit

On September 26, 2006 DPHS and PHIAP will convene public health stakeholders from around the state to review the results of New Hampshire's assessment of the National Public Health Performance Standards, to share the vision for DPHS and the strategic priorities identified by PHIAP.

Six workgroups will be launched and begin the process of developing an action plan for their assigned strategic priority.

FORCES OF CHANGE ANALYSIS
Challenges and Opportunities

What is occurring or might occur in New Hampshire that affects the state public health system and our goal to undertake a public health improvement planning process?

EXTERNAL FORCE AND TRENDS	CHALLENGES	**OPPORTUNITIES**
Example National attention on pandemic avian flu	Diverts attention and resources from existing and more probable public health threats	Opportunity to tighten up emergency response plans
Dependency on federal govt for funding Block grant, workforce dev., CHC, Medicaid to states – shrinking funding	Less funding for workforce development Decreasing funding heading to elimination Decreasing Federal responsibility – transferred to states NH reliance on Fed Funding – elimination of services Follow funding – impacts proactivity and priority setting Population shifting to CHC – greater burden to provide safety net services Lack of infrastructure – reliance on external infrastructure (materials, TA, consultants, CDC assignees)	Opportunity to advocate No alternative but to create local capacity Taylor what you do to your specific needs Make a case for state and federal legislature to increase support Alignment around issues -personal with public health sys. People working together Efficiencies Spotlight on state system alignment

EXTERNAL FORCE AND TRENDS	CHALLENGES	**OPPORTUNITIES**
Discussion of Public Health – where does PH fit? What is it? Identity?	Understanding oriented to personal health care system Not public health language in personal health system Definition based on current funding not core abilities and functions Coordination of Maine, Vermont and other regional areas with NH NH Government existed before public health unlike other states – no designed government public health functions/responsibilities Building a system to meet public health needs versus personal responsibility Lack of public awareness of public health in New Hampshire	Personal health opportunity to take on public health – integration Data exchange Ability to talk about issues Moving agenda to a health system not just personal or public
Leadership	Leadership stronger but will politics interrupt progress Changes can halt initiatives	Alignment – ownership of issues Spread leadership – maintain Sustainability of initiatives
Bringing people together around public health		
Technology	Lack of infrastructure – broadband Lack of connectivity Changes too quick Workforce – training, teaching, expertise Can't pay people enough to stay in the public	Increasing availability of data at the local level allows communities to participate in public health Ability to look a population health – trends and practices

EXTERNAL FORCE AND TRENDS	CHALLENGES	**OPPORTUNITIES**
	sector to do the work Perception of value utility efficiency Lack of security and issues around privacy	Data available sooner – speed EMR as a public health tool – integration between systems Growing resources Standardization Cost efficiencies A ton of data out there to be mined – it's there how to get at it Proactive instead of reactive – resources where they should be Quality Align payment systems with Public health
NH one of the healthiest states	Complacency Not all populations	
Special populations	Aging, minority populations Communication	Key stakeholders are aging and becoming part of the special population Aging baby boomers – expectations values make them not passive Facilitates questioning "healthy state" opportunity to point out disparities and areas of difficulty
Increasing awareness that the medical system model cannot solve today's health issues		Use examples
Ideology, conservatism, suspicion of government – deeply rooted ideas in New Hampshire		Energy of naysayers – get them involved in the process Local control can be local ownership of public health

Improving the Public's Health in New Hampshire

Public Health Improvement
Action Plan Advisory Committee Meeting

May 18, 2006
Local Government Center

In Attendance:

Voting Members: Kathy Bizarro, Thomas Clairmont, Mary Ann Cooney, Laura Davies, Margaret Franckhauser, Kevin Flanagan, Judith Fillion, Susan Friedrich, Yvonne Goldsberry, Marylee Greaves, Jeanie Holt, Kate Kokko, Ann LaFlamme, John Seavey, Anna Thomas, Mary Vaillier-Kaplan

Non-voting Members: Joan Ascheim, Alice Ely, Maureen Farley, Kate Frey, John Martin, Jose Montero

Not Attending: Peter Batula, Marilyn Duffy, Deborah Hogancamp, Russell Jones, Shawn LaFrance, Brian Lockhard, Greg Moore, Mary Nelson, Cindy Rosenwald, Richard Rumba, Norrine Williams

Welcome and Introductions:

Mary Ann Cooney welcomed group members.

Review of Public Health Law: John Martin

John Martin reviewed public health law as it relates to New Hampshire. His detailed presentation was distributed and is available.

Some key messages were:

RSA 128 – establishes health officers

- recommended by town selectmen
- appointed by DHHS
- 3 year terms
- can be removed for good cause
- no required minimum qualifications
- receive variable compensation

♦ Duties include:

- enforcement of public health laws/rules/local ordinances
- sanitary investigations (housing standards/nuisances)

RSA 127 - District Departments of Health – any town or city by vote may unite with another to form a district department of health. Not done in 50 years.

- Board must be created to manage affairs
- Must appoint an health office with specified qualifications
- Does not require recognition of the state and is not governed by the state

- **Police Power** – restraints on personal freedom and property (licensing, sanctions, closing facilities)

- **State vs. local** – state law preempts an ordinance or regulation by local government (i.e. indoor smoking)

Anna Thomas asked about liability of public health workers in an emergency situation working outside their jurisdiction. John Martin replied that they have made changes to the law to deal with this issue. For example, they have asked the Attorney General's office for an opinion on Health Officer's liability. They said that there are protections in place for health officers. Another example is the Derry Hepatitis situation. Volunteers were recruited to assist in the clinics. This raised questions about liability. RSA 508:17 covers volunteers. However, the problem was that the volunteers were being paid. Also, there were questions about worker's compensation and whether or not their licensing entity could discipline them for being outside their normal practice. These questions were addressed with RSA 508:17-A effective 1/1/06. This allows the designation of a public health or public safety incident, which is different from an emergency, where the Department of Safety and the Department of Health and Human Services and recruit agents who would work during those incidents. They would be protected from liability the same as state workers and would be considered state employees for the purpose of worker's compensation.

Kathy Bizarro asked about SB 399. John Martin said that this bill was supposed to provide specific powers to the Commissioner during public health emergencies. It passed the senate with ease and then sailed through the House. However, along the way was attached to other bills and was killed.

State Health Profile: Dotty Bazos

This report is in draft stage and PHIAP members are asked not to share the draft that was distributed.

Some key messages were:

State Health Profile

- **Presented the 10 leading causes of death**

Heart	Diabetes
Cancer	Alzheimer's
CVD	Influenza & pneumonia
CLRD	Suicide
Unintentional injuries	Nephritis

- **Behavioral risks to future health tied to causes of death:**
  - Smoking
  - Sedentary lifestyle
  - Overweight/obesity
  - High fat/low fiber diets
  - Alcohol

- **Changing populations**
  - Aging
  - Increase in minority population

- **Demographics and health**
  - Education, income inversely related to health status
  - Health status behaviors associated with race and ethnicity

- **Need improved capacity and structure for state and regional health profiles**
  - Agree on a subset of indicators
  - Available at an agreed upon geographic service area
  - Monitored annually

Forces of Change Assessment: Joan Ascheim

Joan Ascheim planned on leading the group through a forces of change and community themes and strengths assessment, but ran out of time. She reviewed how these fit into the MAPP – Mobilizing Action Through Planning and Partnerships process. She asked the group if some of this work could be done via e-mail prior to the next meeting and presented to the group. The group agreed.

Next Meeting Agenda: Joan Ascheim

Joan Ascheim said that this will be a critically important meeting. The purpose will be to identify the priorities and strategic issues. She mentioned that some states have identified strategic issues rather than just selecting priority essential services and asked the group if they were open to this. Members seemed to think this made sense. Joan Ascheim said that the meeting will be extended to run through lunch. It will be held 8:30 AM – 2:30 PM

Future Meeting Dates:

The next meeting will be June 15 – Local Government Center – 8:30 AM – 2:30 PM (lunch will be provided).

- Meetings will be held the third Thursdays of the month 9:00 am –12 noon
  - June 15 (8:30 AM – 2:30 PM)
  - September 21
  - October 19
  - November 16
  - December 21

Improving the Public's Health in New Hampshire

Public Health Improvement
Action Plan Advisory Committee Meeting

April 20, 2006
NH Local Government Center

In Attendance:

Voting Members: Bernie Cameron, Thomas Clairmont, Mary Ann Cooney, Judith Fillion, Kevin Flanagan, Margaret Franckhauser, Yvonne Goldsberry, Marylee Greaves, Ned Helms, Russell Jones, MD, Kate Kokko, Representative Cindy Rosenwald, Richard Rumba, Fred Rusczek, Jonathan Stewart, Mary Vaillier-Kaplan, Norinne Williams

Non-voting Members: Joan Ascheim, Lisa Bujno, Maureen Farley, Bridget Fontaine, Emmanuel Mdurvwa, Corinne McCandless, Jose Montero, Neil Twitchell.

Missing: Representative Peter Batula, Kathy Bizarro, Shawn LaFrance, Jeanie Holt, Brian Lockard, Greg Moore, Mary Nelson, James Squires, MD, Representative Deborah Hogancamp

Welcome and Introductions:

Mary Ann Cooney, Director Division of Public Health Services, welcomed everyone and began roundtable introductions.

Web cast Presentation on National Public Health Performance Standards Governance Tool: Liza Corso, Teresa Daub, Tiffany Hinton

Liza Corso and Teresa Daub, of the Centers for Disease Control and Tiffany Hinton, National Association of Local Boards of Health (NALBOH) joined the meeting via web cast and teleconferencing technology. Liza presented the history and concepts of the National Public Health Performance Standards Governance Tool. The governance tool was developed by NALBOH officers and the same federal partners who developed the state and local instrument. It is similarly based on the ten essential services.

The tool is used mostly by governing bodies, generally local boards of health. It assists local boards of health or governing bodies to assess their capacity to support local public health in the areas of legal authority, evaluation, collaboration, policy development and resources. It is often used in tandem with the local instrument.

User benefits of the tool include:

- Validation of the role of the board of health (BOH)
- Awareness of the boards range of responsibilities

- Awareness of potential partners
- Awareness of gaps in services
- Awareness of the need to do strategic planning
- Can be a tool for advocacy
- It can assess strengths and weaknesses in the local public health system.

Experience has shown that it takes about ½ hour per essential service to complete the instrument. It has been done in a variety of ways – from one essential service per meeting to completing the instrument all at one time.

Several questions were asked about how the tool has been used in other states and localities and if regions as opposed to specific towns, cities or counties had used it. Questions were also raised about the tool being done where there is no legal authority and how closely it matches the NACCHO operational definition of public health.

To date the governance tool has not been used in a larger regional setting. New Jersey has used the tool most widely, but focused on the county Boards of Health. The tool was not used by a group of counties or looked at in the aggregate.

Nebraska is just starting to create local health departments and local boards of health and will be using the tool. Nebraska will be scoring the tools and not just using them for discussion

Minnesota did field test the tool and since has used it with a handful of boards of health.

Some advisory boards, which would not have legal authority, have used the tool.

The governance tool is based on the ten essential services, as is the NACCHO operational definition of local health department.

CDC has resources available for states that choose to proceed with the Governance tool. Tiffany is available to facilitate and board members from other states that have used the tool are also available to lend assistance.

Reactions/Ideas/Questions

- Lack of definition for local legal authorities would be a stumbling block for New Hampshire in using the tool. But it could be used for educational purposes.
- Statutes of New Hampshire constitution state that we can not ignore public health
- Pandemic planning may provide an opportunity to utilize the governance tool and look
- Public health networks could work with municipalities to review the tool
- The NH Local Government Center could play a role in bringing groups together to discuss this.
- What are the implications for towns and cities that do not fulfill their statutory obligation relative to public health?
- Focus groups could be conducted for local officials to expose them to the tool.

Focus on State Public Health System Improvement Vs. Local: Mary Ann Cooney

At the March meeting, committee members asked us to clarify if the committee was to focus on state or local public health planning. In response, Mary Ann reviewed the committee's purpose and assumptions.

Purpose of the Advisory Committee

- To guide a process to improve the New Hampshire *(state)* public health system's capacity to provide essential services, with the fundamental purpose to improve the public's health.

(The assumptions can be found in the binder or power point presentation attached to the e-mail accompanying the minutes.) Mary Ann summarized by saying that this committee is planning and setting priorities around state infrastructure and capacity. Joan reviewed some of the suggested priorities, which came out of the assessment meeting in October. These provide some examples of state level performance improvements that could be made.

Mary Ann summarized some local and regional public health planning initiatives. Mary Ann reported that Commissioner John Stephen supports a direction to develop a proposal to the legislature that will assure that local public health preparedness planning takes place. It will be up to the legislature to determine how extensive a regional public health framework will be established. Cities and towns will be required to have preparedness and public health plans. Focus groups of public health professionals will be convened so that everyone can weigh in and give input. The long- term vision is that regional and local public health networks will develop and eventually support with member input governance structure, such as a regional public health council. There are currently 14 public health networks. Bringing areas on board that are not part of a network is challenging due to funding and financial issues. The Division of Public Health is looking at models of supporting regional funding. This may be possible to achieve in the next budget cycle.

Reactions/Ideas/Questions

- It was noted that statutes exist that allow towns to come together to effect change in public health, but they are not enforced.
- Concern was raised about issues like pandemic flu can become distractions that move initiatives such as this planning committee away from priorities such as chronic disease prevention. The need to continually revisit the purpose of the committee and keeping our eyes on the goal of building a strong public health system was emphasized.
- It was noted that towns need a lot of education about public health.
- Kate asked how public health networks should structure themselves given the vision Mary Ann described. Some are becoming non-profits or working with local municipalities. Mary Ann stated they should continue on their current course.
- There were several questions asked about the type of information being gathered about the work of the public health networks. Can we get information about lessons learned by the networks? Jonathan said he could gather this information.

Yvonne stated that they don't have the data locally to evaluate some of the initiatives they are working on, such as diabetes or obesity prevention. It was suggested that lessons learned by the networks be disseminated through newsletters or other mechanisms.

This discussion helped the committee solidify its purpose, to set priorities for public health improvement at the state level.

Turning Point Take Away Messages – Priority Setting: Joan Ascheim

Joan presented a matrix to look at the work of Turning Point in the context of the priorities identified at the assessment meeting in October 2005. She suggested using it when the group got to the prioritization process. Members agreed to this approach.

NH Local Public Health Assessments and Prioritization Processes: Kate Kokko

Kate presented a summary of how various Public Health Networks conducted the assessment of the National Public Health Performance Standards Assessment using the local instrument. She summarized how various networks moved from the assessment process through the prioritization process. (Kate's presentation will be available electronically). Kate provided the following take away messages:

- Local networks used other data in addition to the CDC assessment results to set local priorities. Local expertise was sought before priorities were selected.
- Some overlap exists between state and local assessment priorities such as the creation of a health profile.
- Local need for data was identified as a very high priority. This was not as high a priority at the state level.
- Funding drives local activities. For example, the focus right now of local public health networks is on emergency preparedness, despite the overall public health focus of the assessment and improvement plans.

Revisions to Timeline, Future Meetings, New Members: Joan Ascheim

The group agreed to the revised timeline presented by Joan based on the desire of the group to review more information before setting priorities. Priority setting will take place at the June meeting. The vision meetings taking place in July and August will have a focus on the DPHS and not the entire public health system. Some PHIAP members will be asked to participate in the process along with DPHS staff.

The next meeting will focus on a review of New Hampshire's public health laws and the state health profile.

Joan suggested a meeting in September to bring together all interested stakeholders to hear the results of the public health standards assessment and the priorities set by PHIAP.

Work groups could be launched at this meeting. She suggested inviting Hugh Tilson, a member of the Institute of Medicine report on public health to speak at the meeting. Dr. Tilson is a champion of the performance standards assessment and improvement process. Members were in favor of such a meeting.

New members were suggested at the previous meeting. These included someone from UNH, and a representative from the insurance industry. Joan mentioned that the incoming president for the NH Public Health Association also works for Anthem and could come to the committee wearing two hats. Members agreed this made sense. It was also suggested that someone from Harvard Pilgrim be invited since they have supported public health initiatives. Joan asked how members felt about bringing in new members at this point in time. Members thought May should be the last meeting we bring in new members and that it wouldn't make sense to introduce new members in June when we will be setting priorities. Joan will contact suggested new members and try to bring them on board in May.

Future Meeting Dates:

The next meeting will be May 18 – NH Local Government Center

- Meetings will be held the third Thursdays of the month 9:00 am –12 noon
  - June 15 – NH Local Government Center
  - September 21
  - October 19
  - November 16
  - December 21

Improving the Public's Health in New Hampshire

Public Health Improvement Action Plan Advisory Board Meeting

March 23, 2006
Delta Dental, Building 2

In Attendance:

Voting Members: Representative Peter Batula, Kathy Bizarro, Thomas Clairmont, Margaret Franckhauser, Marylee Greaves, Ned Helms, Representative Deborah Hogancamp, Jeanie Holt, Russell Jones, MD, Kate Kokko, Brian Lockard, Katherine Rannie, Representative Cindy Rosenwald, Richard Rumba, Fred Rusczek, James Squires, MD, Jonathan Stewart, Mary Vaillier-Kaplan

Non-voting Members: Joan Ascheim, Lisa Bujno, Maureen Farley, Bridget Fontaine, Emmanuel Mdurvwa.

Missing: Kevin Flanagan, Yvonne Goldsberry, Marylee Greaves, Shawn LaFrance, Kathy Mandeville, Greg Moore, Mary Nelson, Norinne Williams

Welcome and Introductions:

Dr. Squires welcomed everyone and began roundtable introductions. Joan Ascheim filled in for Mary Ann Cooney who was unable to attend.

Review of Committee Membership and Purpose: Joan Ascheim

A motion was approved to accept the minutes from the February 3rd meeting. Joan reviewed the changes made to the committee purpose, assumptions and voting processes. It was decided that all voting PHIAP members could assign someone to be their designee if they are unable to attend meetings. However, it is incumbent upon the voting member to adequately educate their designee about previous meetings and pertinent issues such that the designee could make an informed vote. Members were asked to provide names and email addresses so their designee can be kept informed of the committee's activities. The committee agreed to use the card voting system as follows:

- orange = "no"
- pink = "discuss"
- green = "yes"

Committee members noted that the report created by this committee should be framed as an action plan and not just a report of committee accomplishments.

Joan asked for suggestions for additional members that could be recruited into the group. The following were suggested:

1. Insurers –because it would be difficult to select one insurer over another, the group thought that they would bring relevant critical issues to insurers rather than have them on the committee
2. Academia
   i. John Seavey
   ii. John McGrath
   iii. Holly Tutko, continuing education
   iv. Dartmouth professors

Comments from Teleconference with PHIAP Members: Joan Ascheim

Joan held a teleconference on March 15th to update members who were unable to attend on February 3rd. Fred Rusczek had some general comments to make regarding core competencies and noted that the local system assessment is only one piece of the CDC assessment process. The governance assessment is also a large part of the process. Russ Jones noted that a communications strategy needs to be developed to keep a broader audience involved in this process.

Discussion of Committee Prioritization Process: Joan Ascheim

Joan suggested a possible prioritization process that the committee could use. The committee reviewed criteria for priority setting. There was agreement to use the suggested criteria but to add: should be measurable and supported by evidenced-based or best practices

Additionally it was noted that that there be language indicating that public health change takes time and thus actions and priorities should be sustainable over a long period of time.

It was also noted that there needs to be a means of evaluating the work, which comes out of the prioritization process. Several PHIAP members or their designees have background in research evaluation and could be part of that process.

Joan will rework the prioritization document for the next meeting. The group voted and approved the use of the matrix to prioritize.

Turning Point Initiatives and Accomplishments: Jonathan Stewart

Jonathan Stewart presented the accomplishments of Turning Point, a two year planning initiative to transform and strengthen the public health system that involved hundreds of individuals and organizations and produced the *Public Health Improvement Plan* for NH.

Discussion following the presentation produced the following comments:

- The state currently has the following data linkage projects in process:
  - Birth and death data
  - Hospital discharge data
  - Cancer registry
- Turning Point provided "future areas of improvement" which is a good starting place for this committee
  - Some of these are being done through Emergency Preparedness process
- Public Health networks are still needed in many areas of the state as shown by the large amount of white areas on public health networks map

Citizens Health Initiative Update: Ned Helms

The Citizens Health Initiative consists of three working policy teams and one working leadership team.

1. Quality of Care
    a. Workforce – access to care
    b. Error prevention
2. Health Promotion/Disease Prevention
    a. What kills us?
    b. What makes us sick?
    c. What makes us healthy?
3. Finance and information
    a. Pay for performance
    b. How to make information compelling and noticeable
    c. Participants:
        i. Foundation for Health Communities
        ii. Center for Public Policy
        iii. Providers

Mobilizing Action Through Planning and Partnerships/Reviewing Additional Information: Joan Ascheim

Joan reviewed the MAPP approach to community planning. MAPP is designed for community planning but some states are using the same process. It is a four-part model including the public health standards assessment, a community health assessment and an analysis of forces of change and community strengths and themes assessment. Joan stated that originally there was thinking that we might want to gather some of this information from communities, but after re-thinking it makes more sense to utilize the advisory committee to gather information from a statewide perspective. For example, the committee could certainly discuss forces of change and state strengths.

Being short on time, Joan recommended sending out a survey to determine what additional information committee members want to hear before prioritizing. The committee thought this made sense and it will be done prior to the next meeting.

Monthly Newsletter/ Next Meeting Agenda: Joan Ascheim

Joan distributed a handout of the proposed monthly newsletter. The newsletter will be sent out via email and will be the main communication tool for PHIAP.

Other suggestions for communication tools:

- NHPHA website
- Professional state organizations
- School nurses newsletter
- Challenge committee members to send to their contacts

Future Meeting Dates:

The next meeting will be April 20 –location TBA

- Meetings will be held the third Thursdays of the month 9:00 am –12 noon
  - April 20
  - May 18
  - June 15 (if needed)
  - September 21
  - October 19
  - November 16
  - December 21

Improving the Public's Health in New Hampshire

Public Health Improvement
Action Plan Advisory Committee Meeting
February 3, 2006
Delta Dental, Building 2, Maine Room

In Attendance:

Mary Ann Cooney, Co-chair, James Squires, Co-chair, Chris Adamski, Karla Armenti, Joan Ascheim, Peter Batula, Kathy Bizarro, Lisa Bujno, Thomas Clairmont, Maureen Farley, Bridget Fontaine, Yvonne Goldsberry, Mary Lee Greaves, Ned Helms, Jeanie Holt, Kate Kokko, Kathy Mandeville, Jose T. Montero, Steve Norton, Katherine Rannie, Richard Rumba, Jonathan Stewart, Norrine Williams

Absent:

Martha Franckhauser, Deborah Hogancamp, Dr. Russell Jones, Brian Lockard, Greg Moore, Mary Nelson, Cindy Rosenwald, Fred Rusczek, Mary Vaillier-Kaplan, Mike Walls

Welcome and Introductions:

Joan Ascheim thanked everyone for volunteering to be part of this important project and began roundtable introductions.

Opening Remarks:
Dr. James Squires and Public Health Director Mary Ann Cooney, Co-chairs

Dr. Squires introduced himself noting that he was not an insider to public health, but has come to understand the importance of public health. That is why he accepted Mary Ann's invitation to participate in this group. As a physician, Dr. Squires has focused on individual health and now finds his focus on group health.

Dr. Squires reviewed the purpose of this advisory committee:

- To guide a process to improve the New Hampshire public health system's capacity to provide essential services.

He spoke to the need to define capacity and essential services.

Dr. Squires spoke about his experience with collaboratives. He noted the importance of the evolving chemistry of the group, ground rules (including a pre-determined way to reach consensus) and a predictable time line. He spoke of the importance of clear communication both within the committee and to those outside a committee and framing public health in terms people will understand.

Dr. Squires spoke about the lack of a public health system in New Hampshire and described it as disjointed, citing a lack of data systems that can talk to one another as an example.

Dr. Squires commented on how the group can get started. He noted that there might not be agreement upon the definitions of the 10 essential services. But he stated that they have been around for some time and are recognized and being used by CDC and a number of states. He therefore urged the group to use them as a starting point.

Dr. Squires suggested we think about incremental change and small areas to make improvement. He suggested that groups might have differing opinions but must respect one another in the process and try to enjoy the process.

Mary Ann Cooney thanked everyone for helping to kick off the process that will be the most important thing that we do for public health. She asked the group to listen to the results of the assessment and determine what is best in New Hampshire. She noted that the State Public Health System (SPHS) needs to build on current strengths and successes and make change based on gaps found during the assessment process. Ms. Cooney thanked everyone who participated in the assessment process in October for coming back to the table to continue the process.

Presentation of Results of the Performance Standards Assessments: Joan Ascheim

Ms. Ascheim presented the results of the New Hampshire Assessment of the National Public Health Performance Standards conducted on October 11 and 12, 2005. The assessment was based on the *Ten Essential Services* as defined by the Centers for Disease Control (CDC). (Please see presentation handouts in section six of you binder for more details.) :

Ms. Ascheim asked members of the board who had participated in local public health assessments to comment on their experience:

Yvonne Goldsberry, Director of Community Health Services at Cheshire Medical Center in Keene, participated in the Cheshire County area assessment. She noted that the process was worthwhile and achieved the following:

- Helped people (especially in the municipal arena) to understand that they were part of the public health system
- Acheived a community consensus regarding the definition of public health system
- Built relationships
- Helped healthcare people to realize the value of having municipal leaders and health officers at the table
- Generated a plan with priorities

Mary Lee Greaves, the Public Health Nurse Coordinator at the Keene Public Health District Office noted that the Cheshire County assessment process also energized the community and created momentum to move forward.

Jonathan Stewart participated in 12 public health network assessments as Executive Director of the Community Health Institute. Mr. Stewart noted that the assessment is a subjective process and the thickness of the assessment tool can be intimidating. He felt that it was important to build collaboration first and then perform the assessment. The results of the assessments in which he was involved were similar to Cheshire County as far as building relationships, defining local

public health systems and implementing a plan with priorities. Mr. Stewart emphasized that the results of the assessment should help to align strategic plans across the system and that non-governmental agencies need to build the results into their practices.

Norrine Williams, Administrator, Ammonoosuc Family Health Services, participated in the Littleton area assessment. She thought that the process was useful and has noticed a difference in the community's focus. Relationships developed during the assessment process are now being used to develop a disaster plan.

Kate Kokko, Director, Southern Strafford County Community Health reported that the process in the Dover area provided the community with a better understanding of public health and gave them something tangible to focus on and move forward with.

Before the break the committee agreed that the following meeting schedule would be conveninent for everyone moving forward:

- Third Thursdays of the month 9:00 am –12 noon (except March)
  - March 23 (fourth Thursday)
  - April 20
  - May 18
  - June 15 (if needed)
  - September 21
  - October 19
  - November 16
  - December 21

Review of committee purpose and assumptions: Joan Ascheim

Purpose:

To guide a process to improve the New Hampshire public health system's capacity to provide essential services. The committee agreed to the purpose as stated in the handouts provided, but clarified that the *local and state* public health system would be the focus.

Assumptions:

The committee made the following comments regarding the assumptions as stated in the handouts:

Recognizes that plans developed to strive towards meeting the National Public Health Performance Standards must consider available resources. The committee suggested changing the language from *available resources* to *available or potential resources*.

Is committed to communicating openly with key stakeholders relative to the planning process. The committee suggested that the following stakeholders should be invited to participate on the Advisory Board:

- Professional communicators (media, marketing)
- Insurers

Approaches / Steps:

The committee made the following comments regarding the approaches/steps as stated in the handouts:

Number 3: To determine a process for setting public health system improvement priorities:

Comments:

- Focus on priorities all ready established by Turning Point program.
- Assess Turning Point status and decide if it needs improvement
- Celebrate successes and look at gaps between conceptual and actual
- Provide communication on areas of opportunity
- Determine three or four issues we could focus on moving forward
- Develop an external communication strategy

Number 4: To articulate priorities based on the results of the assessment of the National Public Health Performance Standards (including scores and discussion)

Comments:

- Major barrier is legal authority

Number 6: To determine what other information/processes we need to consider in developing a plan (health status measures, system strengths, weaknesses, environmental threats and opportunities, vision planning, models of delivery)

Comments:

- How do we share this information between towns and is the money available for this kind of sharing?
- Do we have a vision in mind of what we want to do?
- It is currently left up to each individual town to decide what to do.

Number 8: To determine how/when to share this information with other stakeholders and to obtain their feedback.

Comments:

- Sharing with people who aren't aware of the process may be difficult.
- Should we assess the amount of education that will be needed and the resources needed to accomplish that.

Number 12: To manage and measure public health system improvements in the short term and develop a continuous process of accountability.

Comments:

- Is there another group already established that could manage this?

Other Questions/Comments:

What kind of authority will this group have?

Ms. Cooney answered that this group will act in an advisory capacity. DPHS is seeking input on the decision making process. The group will provide consensus, but all actions will need the approval of the DHHS Commissioner.

What kind of decision-making process will we use?
The committee agreed that the colored voting cards worked well in the assessment process in October and could be useful here. Other voting systems are also available to choose from.

Have any other states conducted an assessment and what is their status?
Fifteen other states have participated in the assessment process. Twelve are in the planning stages. They would all be able to provide information to this group or could be invited to present to this group.

Moving Forward:

- Ms. Cooney and Ms. Ascheim will write up the decision making process to present at the next meeting.

- Ms. Ascheim will invite someone from another state to present the results of their assessment

- Committee members who participated in LPHS assessments will present those results. Volunteers include:
  Jonathan Stewart
  Kate Kokko
  Tom Clairmont will check with the Lakes Region network regarding their results

The next meeting will be March 23.